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ABSTRACT

As states confront budget shortfalls, investment in mental health services faces the chopping block. Almost every state has instituted cost containment strategies in its Medicaid programs and state policymakers have begun to cut services for people with mental health treatment needs. The first part of this report presents research on state cuts to mental health funding and state Medicaid agency reports on mental health spending. Part two of the assessment allowed policymakers, advocates, and the media to evaluate state choices around mental health policy. In particular, this section evaluates whether state policymakers have taken the opportunity to reduce discrimination against people with mental health problems and promote access to community-based mental health services and newer, more effective medications. Part three identifies additional key issues advocates, consumers, family members, and other stakeholders can use to guide strategy sessions with policymakers about mental health services in their states and discussions with other mental health stakeholders and the media. (GCP)

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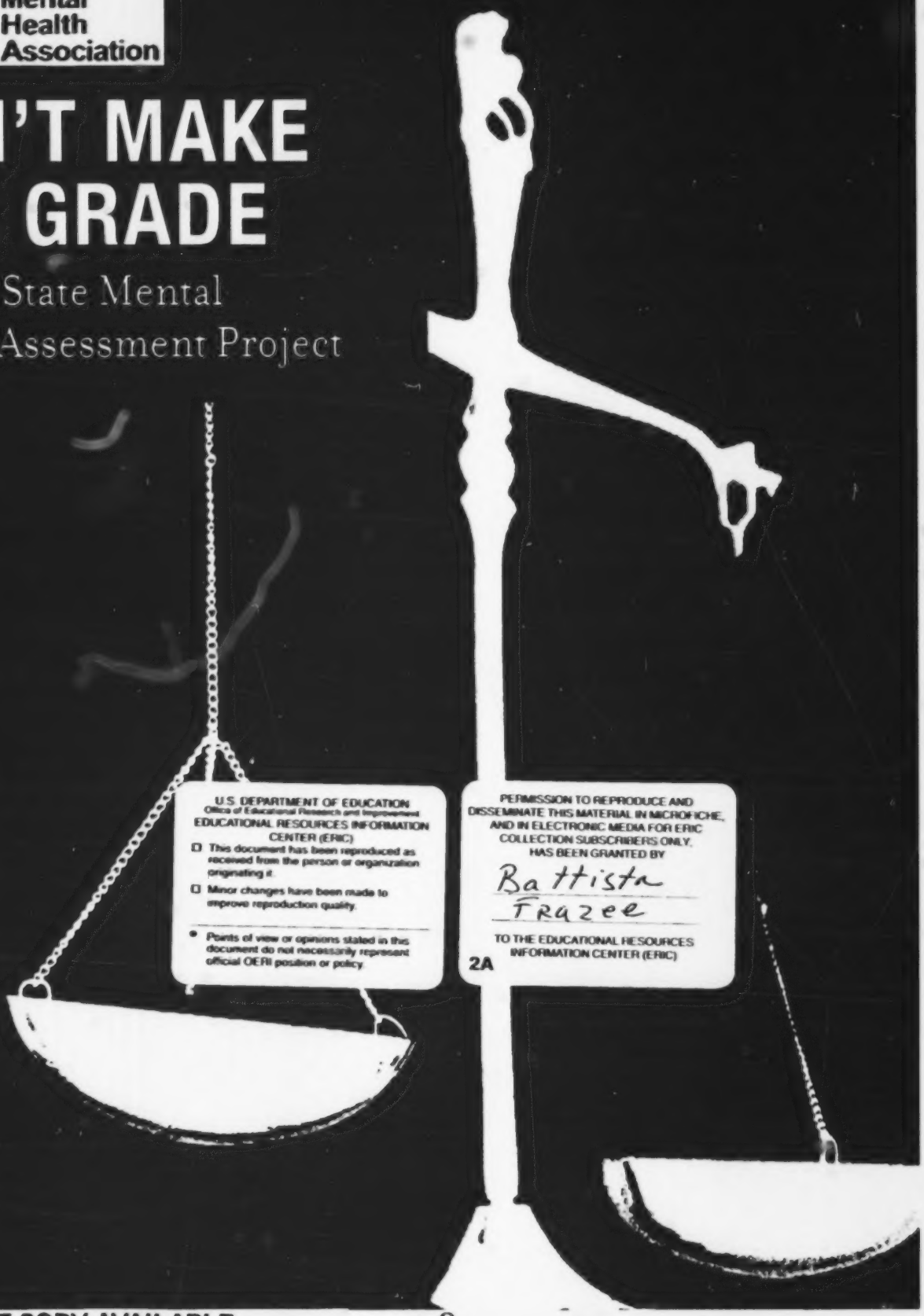
NMHA State Mental Health Assessment Project



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NMHA State Mental Health Assessment Project

About NMHA

The National Mental Health Association is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans through advocacy, education, research and service.

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For an electronic version of the report and additional resources on the topic, please visit www.nmha.org.

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Part I: State Mental Health Funding in Crisis

States Are Slashing Mental Health Funding

As states confront budget shortfalls of more than $80 billion, investment in mental health services once again faces the chopping block. Almost every state has instituted cost containment strategies in its Medicaid programs.[2] And state policymakers have begun to do what should be unthinkable–cut services for people with mental health treatment needs.[3] In August 2002, reports from state policymakers create a grim picture:

- ✘ Policymakers in 29 states cut funding for mental health agencies or mental health services under Medicaid, and over half of all states anticipate cuts next year.
- ✘ Seventeen of the 29 state mental health agencies report that Medicaid cuts will have a negative impact on mental health services.

Table 1 (page 2) shows which states reported cuts or reported anticipating cuts in mental health funding in August 2002. Since then, states have continued to downgrade financial forecasts, and many have already instituted mid-year cuts. For example, Montana, Oklahoma and South Carolina have cut funding for mental health services *multiple times* in the last year, and more cuts are expected for these and other states.

The National Association of State Budget Officers estimates that it will take 12 to 18 months after economic recovery for state budgets to return to normal levels.[4] In 2002, a few states were able to preserve or even increase mental health funding, but most used one-time budget measures such as tapping rainy day and reserve funds.[5] With 2004 looking equally fiscally bleak for state legislatures, it is clear that funding cuts in mental health services have just begun.

"If we do not increase funding for mental health services, we will continue to pay as a nation in hospital and primary health care costs, homelessness, lost productivity, corrections, unemployment and suicide."[1]

– Michael Faenza, president and CEO, NMHA, to the President's New Freedom Commission on Mental Health, 2002

Tricky Business: Medicaid and Mental Health

Medicaid currently accounts for over half of all mental health funding, and has been under increasing scrutiny as states face budget shortfalls and rapidly rising Medicaid costs. State policymakers are blaming increasing Medicaid costs on growing enrollment, prescription drug costs and the rising cost of healthcare services, according to a recent study by the Kaiser Commission on Medicaid and the Uninsured. According to the Commission, 49 states have instituted significant cost controls for 2002 and 2003,[6] with particular focus on:

- ✘ Cutting payment rates to providers
- ✘ Instituting preferred drug lists for medications
- ✘ Reducing benefits and services
- ✘ Reducing eligibility levels for Medicaid

Despite Medicaid's growing role in funding mental health services, many states lack a complete understanding of how Medicaid funds mental health services in their communities.

In spring of 2002, NMHA sent a brief questionnaire to state Medicaid agencies to determine (1) the proportion of mental health funding in the Medicaid budget, (2) the percentage of people enrolled in Medicaid who receive mental health services, and (3) the number of states that report on mental health spending and utilization under Medicaid.

- ✘ Out of 41 responses, only 17 states track mental health spending and utilization under Medicaid.
- ✘ According to the NMHA survey, states spend an average of approximately 9 percent of their Medicaid budget on people with mental illnesses, who make up about 13 percent of the people served.[7]

Many states surveyed could provide only estimates for certain populations (e.g., managed care or fee for service) or types of mental health services, which raises significant questions about the integrity of the data. Without a basic understanding of how funds for mental health services are being used, state policymakers cannot make informed decisions about fiscal policies for mental health services. All states should track funding for mental health services across state agencies.

Table 1: State Cuts to Mental Health Funding

State	Reported Cuts in Mental Health	Anticipate Mental Health Cuts Next Year
Alabama		
Alaska		✘
Arizona		✘
Arkansas	✘	
California	✘	✘
Colorado		
Connecticut	✘	✘
Delaware		
District of Columbia		
Florida	✘	
Georgia	✘	✘
Hawaii		✘
Idaho	✘	
Illinois	✘	✘
Indiana	✘	
Iowa	✘	✘
Kansas		✘
Kentucky	✘	
Louisiana		✘
Maine	✘	✘
Maryland		
Massachusetts	✘	✘
Michigan	✘	
Minnesota	✘	✘
Mississippi	✘	✘
Missouri	✘	✘
Montana	✘	✘
Nebraska		✘
Nevada		✘
New Hampshire		✘
New Jersey		
New Mexico	✘	✘
New York		
North Carolina	✘	✘
North Dakota	✘	✘
Ohio		
Oklahoma	✘	✘
Oregon		✘
Pennsylvania		✘
Rhode Island	✘	✘
South Carolina	✘	✘
South Dakota		
Tennessee	✘	✘
Texas		✘
Utah	✘	✘
Vermont	✘	✘
Virginia	✘	✘
Washington	✘	✘
West Virginia	✘	✘
Wisconsin		✘
Wyoming		
Totals	29	35

Source: 2002 NMHA Survey to Mental Health Agencies, Kaiser Commission on Medicaid and the Uninsured, National Conference of State Legislatures.

The Cost of Under-Investment in Mental Health

The total annual cost of mental illness in the United States is estimated at $205 billion. But the majority of spending related to mental health is the result of under-investent–$105 billion lost in productivity and $8 billion in incarceration and welfare costs each year.[8]

We have a choice: The nation can either invest in public health through community-based services and effective medications, or pay a greater price through higher hospital and primary care costs, greater reliance on correctional facilities, and through increased homelessness, lost productivity and suicide.

Hospital and Primary Care Costs

- ✘ A 30 percent cost reduction in mental health services at a large Connecticut corporation triggered a 37 percent increase in medical care use and sick leave by employees who had previously used mental health services. This cost-cutting measure ultimately cost the corporation money.[9]

Corrections

- ✘ At least 16 percent of the inmate populations of state prisons and local jails are identified as having a mental illness, but few receive the treatment they need.[10]

Homelessness

- ✘ On any given night, more than 600,000 people are homeless in the United States, one-third of whom have a serious mental illness.[11]

Lost Productivity

- ✘ Clinical depression, a treatable condition, costs the United States $24.8 billion in absenteeism and lost productivity each year.[12]

Suicide

- ✘ Alcohol-related suicides among young people cost the United States $1.5 billion in 1998.[13]

Table 2: State Medicaid Reports

State	State Medicaid Agency Reports on Mental Health Spending
Alabama	No
Alaska	No
Arizona	
Arkansas	No
California	No
Colorado	Yes
Connecticut	
Delaware	
District of Columbia	No
Florida	Yes
Georgia	Yes
Hawaii	No
Idaho	No
Illinois	No
Indiana	No
Iowa	
Kansas	
Kentucky	Yes
Louisiana	No
Maine	
Maryland	Yes
Massachusetts	No
Michigan	Yes
Minnesota	No
Mississippi	
Missouri	Yes
Montana	Yes
Nebraska	No
Nevada	Yes
New Hampshire	No
New Jersey	No
New Mexico	
New York	No
North Carolina	Yes
North Dakota	Yes
Ohio	No
Oklahoma	No
Oregon	No
Pennsylvania	Yes
Rhode Island	No
South Carolina	No
South Dakota	No
Tennessee	
Texas	No
Utah	No
Vermont	No
Virginia	Yes
Washington	Yes
West Virginia	No
Wisconsin	
Wyoming	No

Source: NMHA Survey to Medicaid Directors, Spring 2002. Blanks indicate that the state did not respond to that portion of the survey or did not respond to the survey at all.

Part II: State Mental Health Priorities

Although Americans are becoming more aware of mental health issues and are learning how critical mental health is to their daily lives, public policy lags far behind. States often have weak protections for people enrolled in managed care, restrict access to essential medications and lack adequate mental health insurance parity protections.

NMHA recognizes that state policymakers face unprecedented budget shortfalls, new responsibilities to improve state and local security, and increased demand for healthcare services. Yet, we are concerned that many lawmakers are looking for quick fixes to solve complex budget problems. Slashing Medicaid and mental health budgets may appear to reduce costs, but experience shows that these intended savings will only increase costs in other inappropriate service areas such as justice and welfare systems, emergency rooms and primary care settings.

"We must work for a welcoming and compassionate society, a society where no American is dismissed, and no American is forgotten. We must give all Americans who suffer from mental illness the treatment, and the respect, they deserve."

– President Bush, April 29, 2002

Goals for Part II

As every teacher knows, grades only tell a small part of the story about any student. And so it goes that the grades NMHA assigned provide only one piece of a larger picture of each state. Taken as a whole, the graded indicators in each of the three categories (see box at right) provide a targeted assessment of policymakers' commitment to people in their communities who have mental illnesses.

Part II of NMHA's State Mental Health Assessment allows policymakers, advocates and the media to evaluate state choices around mental health policy. In particular, this section evaluates whether state policymakers have taken the opportunity to:

- ✘ Reduce discrimination against people with mental health problems.
- ✘ Promote access to community-based mental health services and newer, more effective medications.

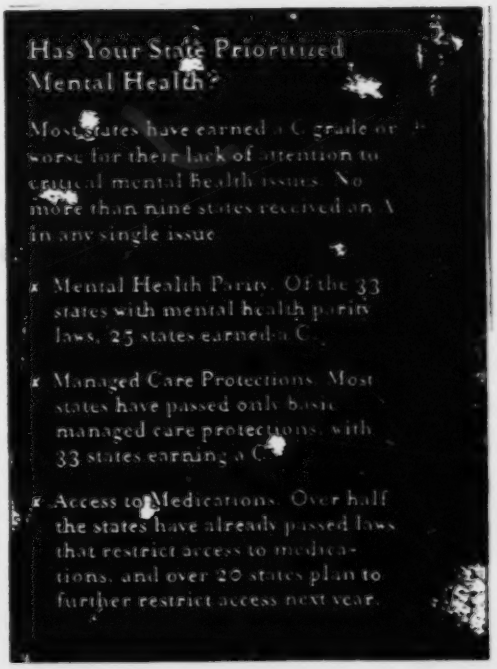
Has Your State Prioritized Mental Health?
Most states have earned a C grade or worse for their lack of attention to critical mental health issues. No more than nine states received an A in any single issue
✘ Mental Health Parity. Of the 33 states with mental health parity laws, 25 states earned a C.
✘ Managed Care Protections. Most states have passed only basic managed care protections, with 33 states earning a C.
✘ Access to Medications. Over half the states have already passed laws that restrict access to medications, and over 20 states plan to further restrict access next year.

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Table 1: Mental Health Insurance Parity

State	Grade
National	D+
Alabama	D
Alaska	D
Arizona	C
Arkansas	C
California	C
Colorado	C
Connecticut	A
Delaware	C
District of Columbia	D
Florida	D
Georgia	D
Hawaii	C
Idaho	F
Illinois	C
Indiana	B
Iowa	F
Kansas	D
Kentucky	B
Louisiana	C
Maine	C
Maryland	A
Massachusetts	C
Michigan	F*
Minnesota	A
Mississippi	D
Missouri	C
Montana	C
Nebraska	C
Nevada	C
New Hampshire	C
New Jersey	C
New Mexico	B
New York	D
North Carolina	C
North Dakota	F
Ohio	D
Oklahoma	C
Oregon	D
Pennsylvania	F*
Rhode Island	B
South Carolina	C
South Dakota	C
Tennessee	C
Texas	C
Utah	C
Vermont	A
Virginia	C
Washington	D
West Virginia	C
Wisconsin	D
Wyoming	F

Source: NMHA Policy Tracking, Health Policy Tracking Service.
**Advocates in Michigan and Pennsylvania overwhelmingly gave their states an F when it comes to mental health parity.*

Mental Health Parity: Ending Insurance Discrimination

Decades of proven medical research tell us that mental illnesses are just as real, common and treatable as physical illnesses. But insurance policies across the nation continue to treat people with mental health treatment needs differently by imposing higher fees and other restrictions on mental health treatment. Families without adequate mental health coverage have gone bankrupt trying to get necessary treatment for a loved one.

"Health plans should not be allowed to apply unfair treatment limitations or financial requirements on mental health benefits."

– President Bush, April 29, 2002

In 1996, Congress passed the Mental Health Parity Act, which requires insurance companies that offer mental health coverage to establish the same annual and lifetime spending limits for physical and mental illnesses.[14] Unfortunately, most companies violate the spirit of the law by taking advantage of loopholes that allow them to place restrictions on visit limits or to increase co-payments.[15] Even though all federal employees enjoy equal access to mental health services through the Federal Employees Health Benefits Program, Congress has failed to require full insurance parity for the rest of the nation. In 2003, policymakers have the opportunity to help solve this problem by passing the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, which would require health plans that offer mental health coverage to offer the same benefits for mental and physical disorders.

Thirty-three states have passed mental health parity laws, but 25 have significant limitations on the diagnoses covered (and the type of discrimination prevented) with post-traumatic stress disorder, eating disorders, substance abuse disorders and children's disorders often excluded.

Grading Criteria

The quality and scope of state parity laws vary widely. Some states have taken small steps toward full parity by passing mental health mandates that either require some level of mental health coverage or offer parity as a choice in a benefits package. Vermont has the most comprehensive parity law in the country.[16]

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What Is Insurance Parity?

Insurance parity means having the same insurance benefits for mental health as for physical health, including:

- ✘ Annual and lifetime spending limits
- ✘ Deductibles
- ✘ Day and visit limits
- ✘ Co-payments

Mental health parity should include all diagnoses in either the latest version of the American Psychiatric Association's, Diagnostic and Statistical Manual for Mental Disorders (DSM) IV or the International Classification of Disease (ICD).

Table 2

Type of Parity Law[17]	Definition	Grade
Comprehensive Parity Laws	1. Broad definition of mental illness. 2. Includes substance abuse. 3. No exemptions.	A
Full Parity Laws	1. Broad definition of mental illness. 2. One or two exemptions, including small businesses exemptions, exclusion of substance abuse or cost increase caps.[18]	B
Limited Parity Laws	1. Law limits protections to certain diagnoses or certain populations. 2. Often includes other exemptions, such as small business exemptions, cost increase caps or addresses only certain types of discrimination.	C
Mental Health Mandate Laws	1. Minimum mandated benefit law requires a minimum of mental health services, or 2. Mandated benefit offering law requires that at least one choice in the benefit package offer mental health parity.	D
No Parity or Mandate Laws	1. No laws requiring mental health parity.	F

The Facts About Mental Health Insurance

- ✘ Employers can limit access to mental health care in various ways–with higher co-pays; restrictive day and visit limits for mental health services; and high annual and lifetime spending limits and deductibles.[19]
- ✘ The level of employers' physical healthcare benefits declined by 11.5 percent between 1988 and 1998 compared to a 54.7 percent decrease in behavioral healthcare benefits during the same time period.[20]
- ✘ Less than half of current state parity laws address children's mental health disorders.
- ✘ The Congressional Budget Office has projected that comprehensive mental health parity, as proposed in pending legislation, would increase insurance premiums by less than 1 percent.[21]
- ✘ More than 80 percent of Americans support ending insurance discrimination, and an overwhelming majority of Americans (79 percent) support parity legislation even if it results in an increase in their health insurance premiums, according to an NMHA poll.[22]
- ✘ Health plans that impose the highest financial barriers to mental health services have higher rates of psychiatric disability claims than plans with easier access to mental health services.[23]

Table 3: Children's Parity

State	Grade
National	D-
Alabama	F
Alaska	F
Arizona	F
Arkansas	F
California	B
Colorado	F
Connecticut	A
Delaware	F
District of Columbia	F
Florida	F
Georgia	F
Hawaii	F
Idaho	F
Illinois	F
Indiana	A
Iowa	F
Kansas	F
Kentucky	A
Louisiana	C
Maine	F
Maryland	A
Massachusetts	B
Michigan	F
Minnesota	A
Mississippi	F
Missouri	F
Montana	F
Nebraska	F
Nevada	F
New Hampshire	F
New Jersey	F
New Mexico	A
New York	F
North Carolina	A
North Dakota	F
Ohio	F
Oklahoma	F
Oregon	F
Pennsylvania	F
Rhode Island	A
South Carolina	C
South Dakota	F
Tennessee	A
Texas	C
Utah	F
Vermont	A
Virginia	F
Washington	F
West Virginia	C
Wisconsin	F

Source: NMHA Policy Tracking, Health Policy Tracking Service

The State of Parity for Children

Approximately one in five children may have a mental health problem, but three-fourths of those children do not receive the help they need.[24]

Of the 33 states that have passed parity laws, less than half address the needs of children who have mental health disorders. This basic failure to make children a priority and provide early intervention and access to treatment means that states will continue to waste funds on crisis care and juvenile justice facilities rather than investing in the type of mental health care that science proves will help children grow into healthy and productive adults.

Grading Criteria

NMHA has added an additional grading table to recognize states that have given high priority to children's mental health in their parity laws. This grading approach builds on the research conducted for all parity laws to examine how state laws specifically affect children.

Again, there is wide variation in the scope of parity legislation. Vermont's broad definition of mental health parity helps ensure that children have access to mental health services. Other states have limited the scope of their parity laws, making it difficult for children to access the care they need.

Table 4

Type of Parity Law	Definition	Grade
Comprehensive Parity	1. Broad definition of mental illness diagnoses in the Diagnostic and Statistical Manual for Mental Disorders (DSM) IV or the International Classification of Disease (ICD).	A
Broad Definition of Children's Disorders	1. Specifically includes all children's mental health disorders in its laws.	B
Specific Children's Diagnoses	1. Specifies a diagnosis specific to children (e.g., ADHD) in its law.	C
Children not addressed	1. Does not define mental illness broadly or mention children's disorders in the law.	F

Managed Care Protections: People With Mental Health Disorders Deserve Patient Protections

Managed care companies historically have not been held legally responsible for the physical or mental injuries that result when they deny access to needed care. To respond to concerns that people who have health problems are being denied their basic rights, states have the opportunity to pass patient protections laws. These managed care protection laws set standards for care, hold health plans legally accountable for negligent harm, and require internal and external review in cases of denied care.

- **Insurer Liability Laws**. Nine states have enacted laws that specifically allow patients to hold health insurance providers liable for negligence and harm.[25] However, two states, California and Washington, have enacted consumer protections that exclude people with "mental injuries" suffered as a result of negligence or denial of care.
- **Patient Protection Laws**. Thirty-three states have passed laws or promulgated rules that ensure some basic protections for consumers. These "patients' bill of rights" laws and regulations define basic requirements for the provision of health care benefits to maintain quality of care. The scope and quality of the content of these laws and regulations vary widely across states.

"If the only thing health plans stand to lose in litigation is the cost of the care they denied, they have every financial incentive to delay and delay and deny and deny."

– Ronald F. Pollack, executive director, Families USA, The Washington Post, July 11, 1999

What Is Managed Care?

Managed care describes healthcare systems that integrate the financing and delivery of appropriate health care services to covered individuals by:

- Arrangements with certain providers to deliver health care services;
- Explicit standards for selection of health care providers;
- Formal programs for ongoing quality assurance and utilization review; and
- Significant financial incentives for members to use providers and procedures associated with the plan.

Source: National Conference of State Legislatures. http://www.ncsl.org/public/catalog/6642ex.htm

Table 5: Managed Care

State	Grade
National	C
Alabama	C
Alaska	C
Arizona	A
Arkansas	C
California	F
Colorado	C
Connecticut	C
Delaware	C
District of Columbia	C
Florida	C
Georgia	A
Hawaii	C
Idaho	C
Illinois	C
Indiana	C
Iowa	C
Kansas	C
Kentucky	C
Louisiana	A
Maine	A
Maryland	C
Massachusetts	C
Michigan	F
Minnesota	C
Mississippi	F
Missouri	C
Montana	C
Nebraska	C
Nevada	C
New Hampshire	C
New Jersey	A
New Mexico	A
New York	C
North Carolina	A
North Dakota	C
Ohio	C
Oklahoma	A
Oregon	A
Pennsylvania	C
Rhode Island	C
South Carolina	C
South Dakota	C
Tennessee	C
Texas	A
Utah	F
Vermont	C
Virginia	C
Washington	F
West Virginia	A
Wisconsin	C
Wyoming	F

Source: American Psychological Association and the National Conference of State Legislature's Health Policy Tracking Service

What Does a Typical Insurer Liability or Patient Protections Bill Address?

Managed care legislation varies widely from state to state, but share some common elements.

Insurance liability bills will generally:

- ✘ Specify the responsibility of the administrator to provide "ordinary care."
- ✘ Hold the health plan accountable for denial of "ordinary care," or hold the health plan liable for the denial, delay or failure to authorize regular medically necessary covered services.
- ✘ Require internal and/or external reviews in cases of denied care.

Patient protections bills will generally:

- ✘ Establish certain rights in order to maintain integrity and quality-of-care.
- ✘ Ban gag clauses.
- ✘ Prohibit the use of financial incentives to deny care.
- ✘ Require consumer grievance procedures.
- ✘ Include continuity-of-care requirements.

Table 5 shows that although many states have passed patient protections laws, few have fully prioritized patients' rights.

Grading Criteria

This indicator focuses on how states prioritize patient rights, taking into account the variation in scope of state laws and regulations. For this analysis, NMHA's grades reflect only the existence of patient protections and insurance liability laws in each state. States that exclude mental health from these managed care protections earn a failing grade for this report.

Table 6

Type of Managed Care Protection	Definition	Grade
Full Liability and Patient Protections Law	1. Full insurer liability law (including mental injuries). 2. Patient protections law.	A
Patient Protections Law	1. Patient protections law with no explicit right to liability clause.	C
No Laws	1. No law, or a law that excludes people with mental injuries.	F

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Access to Psychotropic Medications

For many people who have mental illnesses, access to effective medications is a crucial component of a successful treatment plan. Newer psychotropic medications often have fewer side effects and reduce symptoms for people more effectively than many older medications, but they can also be more expensive.[27]

Fast-rising pharmaceutical expenditures–particularly in state Medicaid programs–make these medications easy targets for cuts in the current budget environment. Twenty-six states have passed laws that limit access to medications. More than 20 states plan to impose new restrictions to medications in their Medicaid programs in 2003, including increased use of prior authorization and monthly prescription limits, according to the Kaiser Commission on Medicaid and the Uninsured.[28]

State policymakers use a variety of strategies to limit access to medications, such as imposing "preferred drug lists" and prior authorization requirements; limiting the number of medications that can be prescribed to an individual; and giving administrative authority for Medicaid Directors to limit access to medications with changing any laws.

Generally speaking, these restrictive policies either limit the medications that consumers may access without special permission or limit the number of medications a consumer may receive in a given period. These limits not only harm people–but also state budgets.

In fact, research demonstrates that reducing access to psychotropic medications will only increase costs in other areas, such as emergency room visits and inpatient care.[29] Choices about medications should be by consumers and their healthcare providers–not by elected officials and bureaucrats.[30]

Limiting Access to Medications Is Pennywise and Pound Foolish:

Studies demonstrate that limiting access to medications through closed formularies and prior authorization requirements only increase costs in other areas.

- ✘ According to federally commissioned independent study conducted by the Lewin Group, any cost savings gained from restrictive formularies are eliminated by increases in spending in other, more expensive, service sectors.[1]

"When you deny access to needed medication, you are playing with people's lives. Ironically, you also cost the system far greater resources in increased hospitalization, emergency room visits, and other expensive interventions."

–Former Indiana State Representative Susan Crosby, 44th District

Table 7: Access to Medications

State	Grade
National	NA
Alabama	
Alaska	
Arizona	
Arkansas	
California	*
Colorado	
Connecticut	P
Delaware	
District of Columbia	
Florida	F
Georgia	F
Hawaii	P
Idaho	
Illinois	P
Indiana	P
Iowa	F
Kansas	P
Kentucky	F
Louisiana	F
Maine	F
Maryland	
Massachusetts	F
Michigan	F
Minnesota	P
Mississippi	F
Missouri	F
Montana	F
Nebraska	
Nevada	
New Hampshire	F
New Jersey	
New Mexico	F
New York	
North Carolina	F
North Dakota	
Ohio	P
Oklahoma	F
Oregon	P
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Texas	
Utah	
Vermont	P
Virginia	
Washington	P
West Virginia	F
Wisconsin	
Wyoming	

Source: National Conference of State Legislatures, Kaiser Commission on Medicaid and the Uninsured, NMHA Policy Tracking.
**In 1990 and again in 2002, California passed AB 442, which changed the rebate structure and established a prior authorization process. While the legislation did not exempt any mental health medications, advocates were able to ensure that mental health medications were not included in the prior authorization process.*

✘ When California's Medicaid program tried to contain costs through restrictive formularies, it found that the average prescription cost per patient increased from $246 to $726, and that the average number of office visits increased from 3.2 to 6.6.[ii]

✘ A 1996 study published in the *American Journal of Managed Care* found that the more restrictive a formulary is, the more often often that patients use other, more expensive, services.[iii]

i The Lewin Group. *Health Plan Benefit Barriers to Access to Pharmaceutical Therapies for Behavioral Health: Findings.* (SAMHA, October 1998).
ii M. Schiller. *A Presciption for Medi-Cal. Action Alert.* (Pacific Research Institute, June 1998).
iii S. B. Horn et al. *American Journal of Managed Care.* (1996).

Grading Criteria

Table 7 highlights states that have clearly chosen to restrict access to psychotropic medications by imposing a limited list of medications, such as a "preferred drug list" or prior authorization process in their Medicaid programs.

Some states have recognized the importance of open access to medications for people diagnosed with mental disorders, and have adopted policies that exempt mental health medications from restrictive policies. This is a crucial emergency measure, but not a solution to the problem. States that exempt mental health medications from these limitations have made an important policy choice but have yet to recognize the importance of full access to all types of medications.

Because states may also limit access to medications in their Medicaid contracts, states that have not passed legislation or a regulation to limit access to medications have not received a grade.

Table 8

Type of Restriction[v]	Definition	Grade
Limited access to medications, with exemptions for mental health medications	1. Law or regulation to establish a preferred drug list, prior authorization process or prescription limit, but exempts mental health medications.	P
Limitation on all types of medications	1. Law or regulation to establish a preferred drug list, prior authorization process or prescription limit.	F

Part III: Beyond Grades: Mental Health Policy Trends

Combined with a severely fragmented service system, the nation's underinvestment in public mental health services threatens the health of all Americans. In Part III of this report, NMHA identifies additional key issues advocates, consumers, family members and other stakeholders can use to guide strategy sessions with policymakers about mental health services in their states and discussions with other mental health stakeholders and the media.

- **Increasing Consumer Involvement.** An office of consumer affairs is one way to increase the important role of consumers in state policymaking.
- **Promoting Diversity Among Mental Health Providers.** States often do not track the race, ethnicity, or preferred language of mental healthcare providers.
- **Enhancing Availability of Medicaid Community-Based Services.** States can eliminate administrative barriers to billing Medicaid for the Psychiatric Rehabilitation Option, which allows states to promote community-based services that focus on functional rehabilitation.
- **Reducing Disincentives to Work.** States who adopt the Medicaid Buy-In Option offer a way for mental health consumers to be employed and still receive mental health benefits under Medicaid.
- **Decreasing the Number of People with Mental Illnesses in the Justice System.** Pre-booking diversion programs are one way states can divert people with mental illnesses from the justice system and into appropriate treatment.
- **Supporting Community-Based Services.** Increasing numbers of states are developing plans to transition people from institutions to community-based services. But only four states have adopted the Home and Community Based Services (HCBS) Waiver specifically for children under age 21 or adults over age 55 with mental health disorders.

Mental health policy involves a variety of state agencies and often competing interests. In these times of fiscal uncertainty, this section offers some concrete ways for states to move forward and make mental health policy a priority.

"Taken as a whole, the [public mental health] system is supposed to function in a coordinated manner; it is supposed to deliver the best possible treatments, services, and supports – but it often falls short."

–President's New Freedom Commission on Mental Health, Interim Report, Oct. 2002

Table 1: Office of Consumer Affairs

State	Existence of an Office of Consumer Affairs
Alabama	Yes
Alaska	Yes
Arizona	No
Arkansas	No
California	Yes
Colorado	Yes
Connecticut	Yes
Delaware	
District of Columbia	Yes
Florida	No
Georgia	Yes
Hawaii	Yes
Idaho	Yes
Illinois	Yes
Indiana	Yes
Iowa	
Kansas	
Kentucky	Yes
Louisiana	No
Maine	Yes
Maryland	Yes
Massachusetts	Yes
Michigan	Yes
Minnesota	No
Mississippi	Yes
Missouri	Yes
Montana	No
Nebraska	Yes
Nevada	No
New Hampshire	Yes
New Jersey	
New Mexico	Yes
New York	Yes
North Carolina	No
North Dakota	No
Ohio	Yes
Oklahoma	Yes
Oregon	Yes
Pennsylvania	Yes
Rhode Island	No
South Carolina	Yes
South Dakota	No
Tennessee	Yes
Texas	Yes
Utah	Yes
Vermont	No
Virginia	Yes
Washington	Yes
West Virginia	No
Wisconsin	Yes
Wyoming	No

Source: NRI, 2001. Note: Blank lines indicate that no response was provided.

State Offices of Consumer Affairs: Increasing Consumer Involvement

Although people with mental illness and their families are the ones most affected by the mental health system, they are often excluded from mental health policymaking and systems reform. NMHA believes that mental health systems in collaboration with consumers and their families will prove to be more responsive and effective in serving individuals with mental health disorders.

Focus groups have revealed that consumers and family members feel excluded from the policy decision-making process in states. Even when consumers and family members are involved, they often feel like tokens or that they are not taken seriously.[33]

States can increase consumer involvement in policymaking for mental health issues by:

- ✘ Requiring consumer and family involvement on all health and mental health advisory boards.
- ✘ Employing mental health consumers and family members within state mental health agencies as well as other agencies that provide mental health services.
- ✘ Establishing an Office of Consumer Affairs.

These steps are by no means an exhaustive list of strategies for empowering consumers of mental health services. However, in examining state practices, these strategies provide a solid starting point for improving consumer involvement in policymaking.

States can begin discussions about the importance of consumer leadership through the development of an Office of Consumer Affairs with clear and real responsibilities, or by investing in consumer leadership in other meaningful ways.[34]

Starting Questions About Mental Health Policy

1. Does your state have an Office of Consumer Affairs with an annual budget?

2. How are mental health consumers included in the development of mental health policy?

3. What steps can your state take to ensure greater consumer involvement in mental health policy development?

"The people who rely on publicly funded mental health or addiction services have an important role in designing the services they receive."

–Substance Abuse and Mental Health Services Administration, 1999[32]

"Disparities in mental health systems exist for racial and ethnic minorities and thus mental illnesses exact a greater toll on their overall health and productivity."

- The U.S. Surgeon General, 2001[35]

Promoting Diversity Among Mental Health Providers

Although 30 percent of the population falls into one of four racial, ethnic or linguistic groups, the vast majority of mental health providers are white. Research reveals that culture has a significant impact on communication between providers and those that they serve. Without state-by-state information about mental health providers, states will be limited in their ability to recruit new providers to address the diverse needs of mental health consumers from various ethnic groups. States need to recruit more people of different ethnic backgrounds to their provider networks.

NMHA could not track the racial and ethnic breakdown of mental health providers in each state because the information is not available on a state-by-state basis. The Bureau of Labor Statistics shows that in 1999:

- 84 percent of psychologists were non-Hispanic white (compared to 74 percent of the total population).
- 10 percent of psychologists were black/African American (compared to 12 percent of total population).
- 4 percent of psychologists were Hispanic/Latino (compared to 11 percent of the total population).
- 3 percent of psychologists were Asian American & Pacific Islander (compared to 4 percent of the total population).
- 1 percent of psychologists were American Indian/Alaskan Native (compared to 1 percent of the total population).[36]

National data on psychology students provides additional insight into the racial and ethnic breakdown of psychologists:

- For full-time doctoral departments of psychology, 82 percent of students are white, 6.4 percent black, 5.0 percent Hispanic, 5.7 percent Asian American, and .8 percent Native American.[37]
- For part-time doctoral departments of psychology, 79 percent of students are white, 11.2 percent are black, 5.9 percent are Hispanic, 2.8 percent are Asian, and .8 percent are Native American.[38]

Without this basic information about mental health providers, states have difficulty developing effective strategies to recruit individuals to the mental health provider field.

The National Association of State Mental Health Program Directors Research Institute (NRI) state profiling data shows that only 21 states

Table 2: Recruitment Programs and Cultural Competence Assessments

State	State Mental Health Agency Programs to Recruit Employees from Minority or Ethnic Groups	Cultural Competence Assessments for Provider Licensing
Alabama	No	
Alaska	No	
Arizona	Yes	Yes
Arkansas	No	
California	Yes	Yes
Colorado	Yes	
Connecticut	Yes	Yes
Delaware		
District of Columbia		Yes
Florida	Yes	
Georgia	No	
Hawaii		
Idaho	No	
Illinois	Yes	
Indiana	Yes	
Iowa		
Kansas		
Kentucky	No	Yes
Louisiana	No	
Maine	Yes	Yes
Maryland	Yes	
Massachusetts	Yes	Yes
Michigan		
Minnesota	Yes	Yes
Mississippi	No	Yes
Missouri	No	
Montana		
Nebraska	Yes	
Nevada	No	
New Hampshire	No	Yes
New Jersey		
New Mexico	Yes	Yes
New York		
North Carolina	Yes	Yes
North Dakota		Yes
Ohio	Yes	
Oklahoma	Yes	Yes
Oregon	No	Yes
Pennsylvania	Yes	
Rhode Island	No	Yes
South Carolina	No	Yes
South Dakota	No	
Tennessee	No	
TexasYes	Yes	
Utah No	Yes	
Vermont	Yes	
Virginia	Yes	
Washington	Yes	
West Virginia	No	
Wisconsin	Yes	Yes
Wyoming		

Source: NRI, 2001. Note: Blank lines indicate that no response was provided.

report having specific programs to recruit persons of diverse backgrounds or other special population employees. The special recruitment initiatives include: advertising in diverse journals, employee referral bonuses, scholarships for students of diverse backgrounds and special training programs.[39]

NRI also found that less than half of states assess cultural competence in their training and licensure programs. While a full assessment of the critical issues surrounding cultural competence in mental healthcare is beyond the scope of this report, NMHA stands ready to help states and communities develop policies and services that include the perspectives of the communities they serve.

An Overall Shortage of Mental Health Providers

The lack of cultural diversity among mental health providers is exacerbated by an overall shortfall in the mental health workforce.[40] Faced with high stress and low paying jobs, many potential providers have turned away from the mental health service sector. While the overall shortage may serve as a complicating factor in recruiting providers of different ethnicities, it is also an opportunity to change the face of the provider community.

A culturally competent mental health system would look very different than the mental health system we see today. Providers would reflect the racial and ethnic make-up of the general population and of their communities, and would provide a full range of services in the languages spoken by

consumers. In addition, state agencies would have plans to ensure that the public mental health system met the needs of diverse populations. But to adhere to these goals, states need to make a dedicated effort to recruit people of different racial and ethnic backgrounds to serve at all levels of the mental health system. Increasing efforts to recruit people from a different racial and ethnic groups and changing provider licensing to assess cultural competence are two ways to address these issues.

Starting Questions About Mental Health Policy

1. Does your mental health authority reflect the diverse makeup of your state?

2. What is your mental health authority doing to support cultural competence and attract professionals to diversity the provider pool in your state?

3. Does your state human services agencies have a cultural competency plan?

4. What are some of the strategies underway in your to state to attract and retain providers into the mental health systems?

Table 3: Provider Shortages

State	Shortage of Mental Health Providers
Alabama	Yes
Alaska	Yes
Arizona	Yes
Arkansas	Yes
California	Yes
Colorado	Yes
Connecticut	Yes
Delaware	Yes
District of Columbia	Yes
Florida	Yes
Georgia	Yes
Hawaii	Yes
Idaho	Yes
Illinois	Yes
Indiana	Yes
Iowa	Yes
Kansas	Yes
Kentucky	Yes
Louisiana	Yes
Maine	Yes
Maryland	Yes
Massachusetts	Yes
Michigan	
Minnesota	Yes
Mississippi	Yes
Missouri	Yes
Montana	Yes
Nebraska	Yes
Nevada	No
New Hampshire	Yes
New Jersey	
New Mexico	Yes
New York	
North Carolina	Yes
North Dakota	Yes
Ohio	Yes
Oklahoma	Yes
Oregon	Yes
Pennsylvania	Yes
Rhode Island	Yes
South Carolina	Yes
South Dakota	Yes
Tennessee	Yes
Texas	Yes
Utah	Yes
Vermont	Yes
Virginia	Yes
Washington	Yes
West Virginia	Yes
Wisconsin	Yes
Wyoming	

Source: NRI, 2001. Note: Blank lines indicate that no response was provided.

Table 4: The Rehab Option

State	Living or Social Skills	Other Rehab Services (5)
Alabama	Both	2
Alaska	One	1
Arizona	Both	2
Arkansas		1
California	Both	3
Colorado	Both	1
Connecticut		
Delaware	Both	3
District of Columbia	Both	4
Florida	Both	1
Georgia	Both	5
Hawaii		2
Idaho	Both	2
Illinois	Both	1
Indiana	Both	2*
Iowa	Both	2*
Kansas	Both	2
Kentucky		0
Louisiana	Both	4
Maine	Both	2
Maryland	Both	3
Massachusetts	One	1
Michigan***	Both	4
Minnesota		1
Mississippi	Both	0
Missouri	Both	2
Montana	Both	3
Nebraska	Both	3
Nevada	Both	4
New Hampshire	Both	4
New Jersey	*	*
New Mexico	One	1
New York	Both	3
North Carolina	Both	3
North Dakota	Both	2
Ohio	Both	4
Oklahoma	Both	2*
Oregon	Both	2
Pennsylvania	**	**
Rhode Island	Both	3
South Carolina	Both	3
South Dakota	One	3
Tennessee	Both	4
Texas	Both	3
Utah	Both	1
Vermont	Both	1
Virginia	Both	0
Washington	One	4
West Virginia	One	2
Wisconsin	Both	4
Wyoming	One	1

Source: Recovery in the Community, Bazelon Center for Mental Health Law, 2001

** New Jersey is in the process of moving toward the rehab option*

*** Pennsylvania has not implemented the psychiatric rehabilitation option in its fee for service system. However, a broad range of rehabilitation services are available in its managed care program, including peer services.*

**** Although Michigan technically has a broad range of services under its rehab option, these types of services are only available on a very limited basis)*

Using Medicaid Options to Promote Community-Based Services

Medicaid has become the primary source of mental healthcare for many low-income people who need mental health treatment. Many who need mental health services lack access to or cannot afford private health insurance and require a broad range of social supports to live in the community successfully.[42] In fact, half of all state public funding for mental health services comes from the Medicaid program.[43]

Because states rely so heavily on Medicaid to support public mental health services, the policy choices states make concerning the Medicaid program are critical for people with mental health disorders. State policymakers have opportunities to broaden the Medicaid program to ensure that people with mental disorders have access to the community-based services that make recovery from mental illness possible.

What is Medicaid?

Medicaid is a federal-state partnership in which the federal government matches state investment in healthcare services by 50 to 80 percent, depending on state poverty levels.

Federal law requires states to provide certain healthcare services (called mandatory services) and allows the states to choose to provide other benefits (called optional services). Many of the most important services for mental health care are optional serv-

ices such as the psychiatric rehabilitation option. States vary widely in what services they elect to provide.

The "Rehab Option" Under Medicaid

The "psychiatric rehabilitation option," or "rehab option," is an optional category of services under Medicaid that are geared to help people live in the community rather than hospitals. (Technically, this option is called "other diagnostic, screening, preventive and rehabilitative services.")[44]

The rehab option is the most flexible option available under Medicaid, and allows states to bill for services that focus on improving social and mental functioning in the community. States that choose to include this option in their Medicaid programs may define it with as many or as few of these types of services as they choose.[45] As listed in column one of Table 4, two of the most critical areas for the option include:

Basic or daily living skills focus on services and activities that help restore the skills needed for independent functioning, such as cooking, budgeting, and personal grooming.

Social skills training addresses the interpersonal skills necessary to living successfully in community settings.

Column two in Table 4 shows the number of these additional services each state has chosen to define under its rehab option:

Residential-support services help people find and maintain housing, provide staff support for group residences, and help consumers address interpersonal issues with their landlords or neighbors. (This option *does not* include room and board.)

Employment-related services can include pre-vocational training, coping skills for the work environment, and behavioral skills training that enable people to participate in the workforce. (This option *does not* include job skills training.)

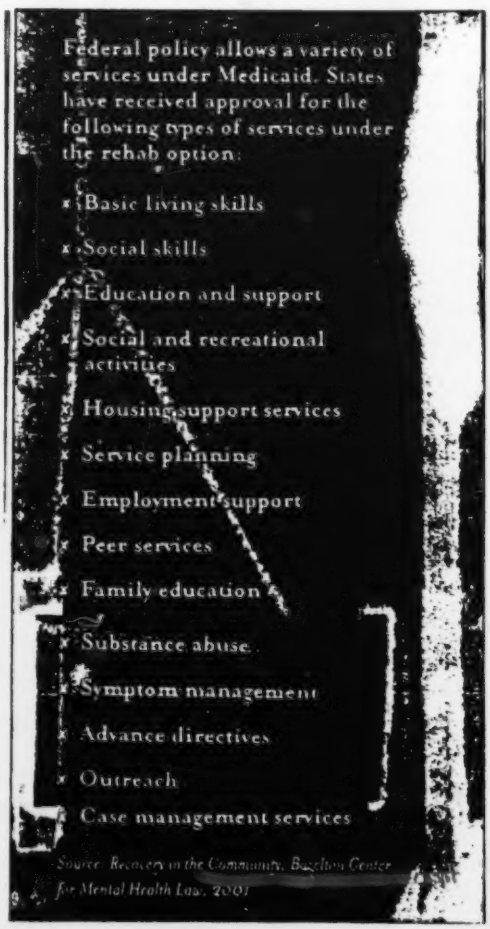
Social and recreational activities do not address purely social activities but do cover services that allow people to practice social skills in various settings.

Family education services teach family members and significant others how to support consumers more effectively.

Peer Services allows people who are diagnosed with mental illnesses to deliver mental health services to other individuals who have mental illnesses. Research has found that peer services are not only effective for the people receiving the services but also for those providing these services. Federal rules do not specify who may deliver services under

"States have sometimes missed opportunities to support flexible, individualized, consumer-driven services based on evidence-based practice. The result is less-than-optimal care for people on Medicaid and additional expenses for the state."

- Bazelon Center for Mental Health Law[41]


Federal policy allows a variety of services under Medicaid. States have received approval for the following types of services under the rehab option:
Basic living skills
Social skills
Education and support
Social and recreational activities
Housing support services
Service planning
Employment support
Peer services
Family education
Substance abuse
Symptom management
Advance directives
Outreach
Case management services
Source: Recovery in the Community, Bazelon Center for Mental Health Law, 2001

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Medicaid, only that they must be supervised by an individual who is a licensed professional of the healing arts. Georgia is the only state to fully operationalize this type of service under the Medicaid rehab option.[45]

Every state in the country, except New Jersey, has adopted the psychiatric rehabilitation option in its Medicaid state plan. However, just because a state offers this option does not mean that these services are available to Medicaid enrollees. In fact, despite Medicaid requirements that all services be available statewide, some states have not fully implemented services under the rehab option or only offer the services in limited areas or populations.

Starting Questions About Mental Health Policy

1. What rehabilitative mental health services are available in your state?

2. Has your state fully implemented its psychiatric rehab option?

3. How can community-based Medicaid mental health services be improved in your state?

State Adoption of the Medicaid Buy-In

Individuals in recovery from mental illness who want to work should be able to without risking their access to healthcare if they are enrolled in Medicaid.[47] However, many Medicaid recipients lose their benefits even by working a few hours a week due to Medicaid income eligibility limits. This has left beneficiaries forced to choose between maintaining health coverage and unemployment or losing healthcare coverage and a seeking a job.

Under the Balanced Budget Act of 1997 (BBA), states now have an option to extend healthcare coverage to workers with disabilities whose income makes them ineligible for Medicaid but they cannot afford private health insurance.[48] The Medicaid Buy-In program allows people on Social Security Disability Income (SSDI) or Social Security Income (SSI) and whose income exceeds the state Medicaid eligibility thresholds to pay a premium and *buy in* to their Medicaid benefits on a sliding scale.

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) expands on the benefits provided under the BBA. It allows states to determine their own income eligibility thresholds. Most states use the standard income threshold of 250 percent of the Federal Poverty Level (FPL). However, certain states have opted to increase their income limit or allow anyone to maintain their benefits regardless of their income level.[49]

About half of states have chosen to adopt the Medicaid Buy-In program, but implementation has been slow, and the current fiscal environment has led to states halting or delaying efforts to adopt this program. But it is an important opportunity for states to eliminate disincentives to people with disabilities to seek employment.

Starting Questions About Mental Health Policy

1. What are some challenges to implementing the Medicaid Buy-In program in your state?

2. How are people with mental disorders impacted by these programs?

3. What other policies and programs support employment for people with mental health needs?

Table 5: Medicaid Buy-In

State	Adoption of Medicaid Buy-in
Alabama	No
Alaska	Yes
Arizona	No
Arkansas	Yes
California	Yes
Colorado	No
Connecticut	Yes
Delaware	No
District of Columbia	No
Florida	Yes
Georgia	No
Hawaii	No
Idaho	No
Illinois	Yes
Indiana	Yes
Iowa	Yes
Kansas	Yes
Kentucky	No
Louisiana	No
Maine	Yes
Maryland	No
Massachusetts	Yes
Michigan	No
Minnesota	Yes
Mississippi	Yes
Missouri	Yes
Montana	No
Nebraska	Yes
Nevada	No
New Hampshire	Yes
New Jersey	Yes
New Mexico	Yes
New York	Yes
North Carolina	No
North Dakota	No
Ohio	No
Oklahoma	No
Oregon	Yes
Pennsylvania	Yes
Rhode Island	No
South Carolina	Yes
South Dakota	No
Tennessee	No
Texas	No
Utah	Yes
Vermont	Yes
Virginia	No
Washington	Yes
West Virginia	No
Wisconsin	Yes
Wyoming	Yes

Source: Social Security Administration, 2002

Table 6: Pre-Booking Diversion Programs

State	Adults	Youth
Alabama	No	No
Alaska	No	No
Arizona	Yes	No
Arkansas		No
California	No	Yes
Colorado	Yes	Yes
Connecticut	No	No
Delaware		
District of Columbia		
Florida	No	Yes
Georgia	Yes	Yes
Hawaii	Yes	Yes
Idaho	No	No
Illinois	No	Yes
Indiana	No	No
Iowa		
Kansas		
Kentucky	Yes	Yes
Louisiana	No	No
Maine	No	No
Maryland	Yes	No
Massachusetts	Yes	Yes
Michigan*	Yes	Yes
Minnesota	No	Yes
Mississippi	No	No
Missouri	No	Yes
Montana	No	No
Nebraska	No	No
Nevada	No	No
New Hampshire	No	Yes
New Jersey		
New Mexico	Yes	Yes
New York	No	Yes
North Carolina	No	Yes
North Dakota	No	No
Ohio	Yes	Yes
Oklahoma	No	No
Oregon	Yes	Yes
Pennsylvania	No	Yes
Rhode Island	Yes	
South Carolina		
South Dakota	No	No
Tennessee	No	Yes
Texas	No	No
Utah	No	No
Vermont	No	No
Virginia	No	No
Washington	Yes	Yes
West Virginia	No	No
Wisconsin	Yes	No
Wyoming	No	No

Source: NRI, 2001. Note: Blank lines indicate that no response was provided.

** In a study of three jails in Michigan, over half of the population in each jail had a severe mental illness and/or substance abuse disorder.*

Diverting People With Mental Health Problems From the Criminal Justice System

The criminal justice system is ill equipped to meet the many needs of people with mental illnesses. Yet most children in juvenile justice facilities and many adults in jails and prisons have mental health disorders. Warehousing people who have mental illnesses in jails, prisons and juvenile detention facilities is not only unhealthy and unproductive for the people being detained, but is also a waste of state funds.

- ✘ More than 90 percent of children admitted to the juvenile justice system are believed to have untreated serious mental or emotional disorders.[50]
- ✘ Approximately 16 percent of the nation's jail and prison population has a mental illness.[51]

Law enforcement officials, judges, mental health professionals and family members agree that the criminal justice system should not be the primary provider of mental health services for children or adults with mental health treatment needs.[52] Instead, states and communities must adopt effective policies to prevent these individuals from entering the nation's jails, prisons, and juvenile justice facilities, including:

- ✘ Pre-arrest diversion programs
- ✘ Pre-booking diversion programs
- ✘ Post-booking diversion programs

Using data from the NRI state profiling study, Table 6 presents responses on whether states have pre-booking programs to divert adults and children from the criminal justice system and into treatment.

Pre-booking diversion programs provide opportunities for people in police custody to receive mental health screenings. If an individual is found to have a mental health disorder, he or she would be diverted directly to mental health services. Studies show that diversion of persons with mental illnesses accused of misdemeanor crimes into appropriate, community-based mental health treatment programs reduces recidivism and contributes to better long-term results for offenders.[53] These programs are not mental health courts, but programs to help people with mental illness avoid encounters with the criminal system as much as possible.[54]

The other category in the NRI study is post-booking diversion programs, an example of which are mental health courts. Using NRI data, Table 7 lists the 16 states that have adopted mental health courts in certain communities.

Mental health courts hear cases involving persons with mental illness who have been charged with non-violent crimes. These individuals are diverted from jail or prison to mental health treatment programs, which might include psychotropic medications, case management and/or inpatient hospitalization to provide them with mental health treatment.

Unfortunately, post-booking diversion programs such as mental health courts increase the use of coercion because the courts rather than the consumer determine the course of treatment. With the new understanding of recovery as the goal of mental health treatment, NMHA is wary of the expanded use of the criminal justice system as the primary way to access community-based treatment.

Ultimately, pre-booking and post-booking diversion programs should aim to dismiss criminal charges. To minimize the coercive nature of these programs, conditions of deferred prosecution, deferred sentence or probation should not exceed one year. States should seek a variety of ways to divert people with mental illness away from the criminal justice system and into to effective services.

Starting Questions About Mental Health Policy

1. How many adults in your state's justice system receive mental health services? How many youth?

2. What public education and training programs have been established for state and local enforcement officials?

3. How can lawmakers, state corrections officials, mental health stakeholders, and others decrease the number of people with mental illness in the correctional system?

Table 7: Mental Health Courts

State	Any Mental Health Courts
Alabama	Yes
Alaska	Yes
Arizona	No
Arkansas	No
California	Yes
Colorado	No
Connecticut	No
Delaware	No
District of Columbia	
Florida	Yes
Georgia	Yes
Hawaii	No
Idaho	No
Illinois	No
Indiana	No
Iowa	
Kansas	
Kentucky	No
Louisiana	No
Maine	No
Maryland	No
Massachusetts	No
Michigan	No
Minnesota	No
Mississippi	No
Missouri	Yes
Montana	No
Nebraska	No
Nevada	Yes
New Hampshire	Yes
New Jersey	No
New Mexico	No
New York	Yes
North Carolina	Yes
North Dakota	No
Ohio	Yes
Oklahoma	No
Oregon	No
Pennsylvania	Yes
Rhode Island	Yes
South Carolina	
South Dakota	No
Tennessee	Yes
Texas	No
Utah	Yes
Vermont	No
Virginia	No
Washington	Yes
West Virginia	No
Wisconsin	No
Wyoming	No

Source: NRI, 2001. Note: Blank lines indicate that no response was provided.

Table 8: Community-Based Services

State	Plan to Transition People to Community-Based services
Alabama	Yes
Alaska	Yes
Arizona	No
Arkansas	No
California	Yes
Colorado	Yes
Connecticut	Yes
Delaware	
District of Columbia	
Florida	Yes
Georgia	Yes
Hawaii	Yes
Idaho	No
Illinois	Yes
Indiana	Yes
Iowa	
Kansas	
Kentucky	Yes
Louisiana	Yes
Maine	Yes
Maryland	Yes
Massachusetts	Yes
Michigan*	Yes
Minnesota	Yes
Mississippi	Yes
Missouri	Yes
Montana	Yes
Nebraska	No
Nevada	Yes
New Hampshire	Yes
New Jersey	
New Mexico	Yes
New York	
North Carolina	Yes
North Dakota	No
Ohio	Yes
Oklahoma	Yes
Oregon	Yes
Pennsylvania	Yes
Rhode Island	Yes
South Carolina	Yes
South Dakota	No
Tennessee	Yes
Texas	Yes
Utah	No
Vermont	Yes
Virginia	Yes
Washington	Yes
West Virginia	No
Wisconsin	Yes
Wyoming	Yes

Source: NRI, 2001. Note: Blank lines indicate that no response was provided.
**According to our Michigan affiliate, the state's transitioning has moved thousands of individuals into communities without adequate clinical and support services in place.*

Olmstead: Plans for Transitioning to Community-Based Services

In its 1999 *Olmstead* decision, the U.S. Supreme Court ruled that the Americans with Disabilities Act (ADA) prohibits states from keeping people with disabilities in institutions simply because there are not enough community-based services. Based on that decision, states are now required to move individuals with disabilities (including those with mental illnesses) out of state institutions and into communities at a reasonable pace. States can demonstrate compliance with this ruling when they have:

- ✘ Developed a comprehensive process for moving qualified people with disabilities to less restrictive settings; and
- ✘ Ensured that waiting lists for services in the community that move at a reasonable pace and are not controlled by efforts to keep institutions fully populated.

Although 42 states have some type of workgroup in place to assess long-term care, only a few states have developed and implemented *Olmstead* plans. Budget shortfalls are slowing efforts further.[55]

Using data from the NRI state profiling survey, NMHA identified states that have plans to transition people from institution-based care to community-based services. This indicator does not capture the extent to which states are complying with *Olmstead*, but establishes whether states have begun that process by establishing a plan to move people with mental disorders out of institutions. This planning process offers an important opportunity for states to collaborate with stakeholders to develop and implement effective *Olmstead* plans.

Starting Questions About Mental Health Policy

1. What are the state efforts to move investment in funds for institutions into community-based services?

2. How will the state strengthen the community-based mental health system to enable people to live successfully in the community?

3. Have consumers and family members been involved in the planning process?

Using the Home and Community Based Services Waiver (HCBS)

A federal Home and Community Based Services waiver (HCBS) allows states to use Medicaid funds dedicated to the care of people in hospitals, residential facilities, and nursing homes to pay for services that enable these individuals to live in the community. As beneficial as this waiver may be, there are two limitations to how states can use the HCBS waiver. First, the amount of federal funds spent must remain the same after a waiver is implemented. For people who have a mental illness, it is usually far more cost-effective to treat someone in the community than in an institution.

The second limitation is specific to people who reside in psychiatric facilities. Under Medicaid law, states cannot seek reimbursement for services provided to adults between the ages of 21 and 64 in Institutions for Mental Disease (IMD). IMDs are hospitals, nursing homes, or other long term care institutions with more than 16 beds with the primary function of providing diagnosis, treatment, or care to people diagnosed with mental illness.

Even though states cannot use the HCBS waiver for adults age 21 to 64, states can take advantage of this option for children younger than 21 or adults older than 64. Although many states have adopted HCBS waivers for people with developmental disabilities or mental retardation, but few have adopted the waiver specifically for people with mental illnesses.[58] States have apparently either misunderstood that the waiver can be used for children or older adults with mental illness or have not chosen to implement the program.

Only four states have adopted the HCBS waiver for children or older adults with mental disorders–Colorado (adults), Kansas (children), New York (children) and Vermont (children). As states continue to seek ways to fund community-based mental health services for people across all age groups, HCBS waivers may be one way to meet some of those needs.

Starting Questions About Mental Health Policy

1. Does the state plan to adopt the HCBS waiver for children or older adults with mental disorders?

2. What steps has the state taken to implement the HCBS waiver?

3. Has the state implemented the HCBS waiver for people with developmental disabilities or mental retardation?

Table 9: HCBS Waiver

State	Home and Community Based Waiver
Alabama	
Alaska	
Arizona	
Arkansas	
California	
Colorado	Older Adults
Connecticut	
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	
Idaho	
Illinois	
Indiana	
Iowa	
Kansas	Children
Kentucky	
Louisiana	
Maine	
Maryland	
Massachusetts	
Michigan	
Minnesota	
Mississippi	
Missouri	
Montana	
Nebraska	
Nevada	
New Hampshire	
New Jersey	
New Mexico	
New York	Children
North Carolina	
North Dakota	
Ohio	
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Texas	
Utah	
Vermont	Children
Virginia	
Washington	
West Virginia	
Wisconsin	
Wyoming	

Source: Center for Medicare and Medicaid Services, 2002

Endnotes

1 M. Faenza. "Mental Health Commission is Good Step, But Not Nearly Enough." NMHA News Release, www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=410.

2 V. Smith, E. Ellis, K. Gifford, R. Ramesh, and V. Wachino. *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003.* (Kaiser Commission on Medicaid and the Uninsured, January 2003).

3 National Conference of State Legislatures. *State Budget Gap Deepens to $58 Billion: More than half of states' revenues fall short of previous year.* (July 2002), www.ncsl.org/programs/press/2002/pr20724a.htm.

4 National Association of State Budget Officers. *Quick Rebound? State Fiscal Recovery Could be Gradual, Lag National Economy by 12-18 Months.* (Washington, DC: NASBO, 2002), http://www.nasbo.org/Publications/PDFs/reboundlag.pdf

5 States that were able to preserve or even increase funding for mental health services include: AL, AZ, DC, FL, HI, IN, KS, LA, MD, NE, NV, NH, NJ, NY, OH, OR, PA, SD, TN, WI, WY.

6 Smith et al, 2003.

7 NMHA Survey to Medicaid Directors, Spring 2002. Responses varied widely. Some states reported only .01 percent of persons under Medicaid received mental health services, while others reported that over half received services. Likewise, mental health services were reported to make up as much as 29 percent of the Medicaid budget or as little as 1.47 percent. The data provided did not appear accurate enough to report in detail.

8 D. P. Rice and L. S. Miller. "Health economics and cost implications of anxiety and other mental disorders in the United States." *British Journal of Psychiatry*, 173(34), 1998: 4-9.

9 R. A. Rosenheck, B. Druss, M. Stolar, D. Leslie, & W. Sledge. Effect of declining mental health service use on employees of a large corporation: General health costs and sick days when mental health spending was cutback at one large self-insured company. *Journal of Health Affairs* (18)5, 1999.

10 Mental Illness and the Criminal Justice System, www.geocities.com/stargazers_here/mental_illness.html (date unavailable).

11 Center for Mental Health Services, Homeless Programs Branch, 2002, http://www.mentalhealth.org/cmhs/Homelessness/about.asp

12 K. Collins. Cost/Benefit Analysis Shows EAP's Value to Employer. *EAPA Exchange*, 1998.

13 Children's Safety Network (CSN), *Economics and Insurance Resource Center, and Pacific Institute for Research and Evaluation. Cost of Alcohol-Attributable Youth Suicide, 1999*, http://www.csneirc.org/pubs/youthetoh/etoh-suicide.htm.

14 The 1996 Mental Health Parity Act requires insurance companies that offer mental health benefits to have parity in annual and spending limits, but not in other areas of discrimination. Employers with fewer than 50 employees are exempt and insurance companies can opt out of the requirement if they can prove that costs increased by more than 1% as a result of the law. Substance Abuse is not included.

15 General Accounting Office. "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited." (GAO/HEHS - 00-85, March 31, 2000).

16 Find the Vermont law at http://www.leg.state.vt.us/docs/1998/acts/ACT025.HTM.

17 NMHA has analyzed laws directly, and has also used resources from: NCSL's Health Policy Tracking Service, Lexis Nexis, and communication with NMHA affiliates. Some states may have mandated benefit offering or minimum mandated benefits laws, but NMHA does not consider those laws to be parity because they do not require coverage *equal* to physical health problems.

18 Exemptions may include: number of employees, excluding substance abuse, or a cost-increase cap.

19 Some insurance companies also impose higher annual and lifetime spending limits. However, this is against federal law. The Mental Health Parity Act of 1996 requires all companies with more than 50 employees to provide parity in lifetime and annual spending limits if any mental health services are offered.

20 HayGroup. Healthcare Plan Design and Cost Trends - 1988 through 1998. Prepared for National Association of Psychiatric

Health Systems and Association of Behavioral Group Practices. (Arlington, VA: HayGroup, 1999).

21 Letter from the Director of the Congressional Budget Office to the Chairman of the Senate Committee on Health, Education, Labor and Pensions (setting forth CBO's cost estimate on the Mental Health Equitable Treatment Act of 2001, as reported by the Senate Committee on Health, Education, Labor and Pensions). Senate Report 107-61, September 6, 2001.

22 NMHA poll (Fall, 2002), http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=461

23 D. Salkever et al. "Disability management, employee health and fringe benefits and long-term disability claims for mental disorders: An empirical exploration." *The Milbank Quarterly*, April 2000.

24 RAND Health Publications. "RAND Health Research Highlights: Mental Health Care for Youth" (2001), www.rand.org/publications/RB/RB4541/

25 States may also establish patient protections in their regulations process or in their contracting process with managed care organizations.

26 Health Policy Tracking Service. Issue Briefs: Managed Care Liability Laws and Patients Protections Laws. (Colorado: National Conference of State Legislators, Summer, 2002). American Psychological Association Analysis.

27 D. Del Paggio, P. Finley, and J. Cavano. "Clinical and Economic Outcomes Associated with Olanzapine for the Treatment of Psychotic Symptoms in a County Mental Health Population." Clinical Therapeutics 24.5 (2002): 803-817. D. Dobrez, et al. Antidepressant treatment for depression: Total charges and therapy duration. *Center for Policy Research*. (2000, December). P. J. Neumann, E. A. Sandberg, C. M. Bell, P. W. Stone, P.W., and R. H. Chapman. Are pharmaceuticals cost effective? A review of the evidence. *Health Affairs*, 19, 92-109, 2000.

28 The Kaiser Commission on Medicaid and the Uninsured. "State Budgets Under Stress: How Are States Planning to Reduce the Growth in Medicaid Costs?" (Washington, DC: The Henry J. Kaiser Family Foundation, July 30, 2002), www.kff.org.

29 The Lewin Group. Health Plan Benefit Barriers to Access to Pharmaceutical Therapies for Behavioral Health. 1998.

30 NMHA's Policy Positions on Restrictive Formularies, http://www.nmha.org/position/ps39.cfm

31 NMHA Analysis; Health Policy Tracking Service, National Conference of State Legislatures.

32 Substance Abuse and Mental Health Services Administration (SAMHSA). *Partners in Planning: Consumer's Role in contracting for Public Sector—Managed Mental Health and Addiction Services, A Quick Reference Guide*. SAMHSA, U.S. Department of Health and Human Services, DHHS Publication Number 99-3312 (1999).

33 National Mental Health Association (NMHA). Consumer Involvement in Healthcare Reform, 2001.

34 Ibid. p. 12-13

35 U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. (Rockville, MD: U.S. Department of Health and Human Services, Public Health Services, Office of the Surgeon General, 2001).

36 HRSA State Workforce Profiles (2000), http://bhpr.hrsa.gov/oldhealthworkforce/profiles/default.htm

37 American Psychological Association, Race & Ethnicity Data (2000), http://research.apa.org/racefig1.html.

38 Ibid.

39 NRI, 2002

40 U. S. Department of Health and Human Services, pp. 32-33. Research has found both the overidentification of schizophrenia among African Americans as well as the underidentification of African Americans for schizophrenia, bipolar, and depression.

41 Bazelon Center for Mental Health Law (November 2001). *Recovery in the Community: Funding Mental Health Rehabilitative Approaches Under Medicaid*. Washington, DC: Bazelon Center for Mental Health Law.

42 R. M. Coffey, T. Mark, and others. National Expenditures for Mental Health and Substance Abuse Treatment 1997. (Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Center for Substance Abuse Treatment, July 2000).

43 Ibid.

44 Bazelon Center for Mental Health Law, 2001.

[45] Ibid.

[46] Ibid, p. 28

[47] National Mental Health Association (NMHA). *Employment Development for Services for Adults in Recovery from Mental Illness.* (Alexandria, VA: NMHA), http://www.nmha.org/position/ps30.cfm

[48] SSI Coalition (SSIC) *Access to Healthcare for Working People with Disabilities.* (Chicago: SSIC, January 2000), http://www.ssic.org/primer.html

[49] S. Cinsavich and G. Rado. "Medicaid buy-in: Concept and implementation." *Institute for Community Inclusion* (April 2002).

[50] National Mental Health Association (NMHA). *The Mental Health Treatment Needs of Kids in the Juvenile Justice System.* (Alexandria, VA: NMHA), http://www.nmha.org/position/ps030198b.cfm

[51] J. F. Fox, P. C. Morschauser, S. Banks, J. L. Stone, "A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems," *Journal of Behavioral Health Services and Research*, 28:2, May 2001, pp. 177-87.

[52] Coalition For Juvenile Justice. "Handle with care: Serving the mental health needs of young offenders." *Coalition for Juvenile Justice*, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs and U.S. Department of Justice (2000). P. M. Ditton. *Mental health and treatment of inmates and probationers* [Special Report]. Bureau of Justice Statistics, U.S. Department of Justice (1999, July). As of 1998, 283,800 prison and jail inmates (16 percent of state prison inmates and 16 percent of local jail inmates) reported a mental condition or an overnight stay in a mental hospital. Additionally, inmates who reported a mental condition were twice as likely to have been homeless in the 12 months prior to their arrest.

[53] Center on Crime, Communities and Culture, 1996.

[54] There are two basic models of diversion. Under the predominate model, a person is assigned to a service program, and criminal charges are suspended or dropped. Any program that provides for dismissal of charges or deferred prosecution, even after arraignment, is considered to be "meaningful diversion." Programs in which people are assigned to probation after a plea of guilty are sometimes referred to as diversion. However, these programs are only a diversion from incarceration and not diversion from the criminal justice system. Pre-booking diversion programs truly divert a person with a mental illness from entering the criminal justice system at all. Rather than having to enter a system that is fundamentally coercive, even if charges were dropped, a participant would have the option of participating in a full continuum of community services.

[55] W. Fox-Grage, D. Folkemer, J. Lewis. *The States' Response to the* Olmstead *Decision: How are States Complying?* (National Conference of State Legislatures: 2003), www.ncsl.org.

[56] Currently, federal Medicaid law prohibits reimbursement for inpatient services for adults aged 21 to 64 residing in an "Institution for Mental Disease" (IMD), which is described as an institution with more than 16 beds, at least half of which are dedicated to psychiatric care. However, states may be reimbursed for IMD services for people under 21 or over 64. States must submit a Home and Community Based Waiver to provide services for children and older adults in the community rather than in an institution.

CAN'T MAKE THE GRADE

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